

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>249</u>	Skilled (SNF)	<u>249</u>	<u>90,885</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>249</u>	TOTALS	<u>249</u>	<u>90,885</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>30,646</u>	<u>5,609</u>	<u>9,576</u>	<u>45,831</u>	8
9	SNF/PED					9
10	ICF	<u>19,437</u>	<u>1,500</u>		<u>20,937</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>50,083</u>	<u>7,109</u>	<u>9,576</u>	<u>66,768</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.46%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 6/5/00

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 6/5/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 50 and days of care provided 9576

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	279,090	91,271	8,168	378,529		378,529	28	378,557		1
2	Food Purchase		321,025		321,025	(26,828)	294,198	(2,062)	292,136		2
3	Housekeeping	223,349	54,019	23,851	301,219		301,219		301,219		3
4	Laundry	70,376	24,655		95,031		95,031		95,031		4
5	Heat and Other Utilities			126,556	126,556		126,556	(12,330)	114,226		5
6	Maintenance	96,432	25,108	178,544	300,084		300,084	1,140	301,224		6
7	Other (specify):*							35	35		7
8	TOTAL General Services	669,247	516,078	337,119	1,522,444	(26,828)	1,495,617	(13,189)	1,482,428		8
	B. Health Care and Programs										
9	Medical Director			20,004	20,004		20,004		20,004		9
10	Nursing and Medical Records	2,518,269	215,090	304,169	3,037,528		3,037,528	981	3,038,509		10
10a	Therapy	48,266	13,556	3,115	64,937		64,937		64,937		10a
11	Activities	164,457	13,652	2,437	180,546		180,546		180,546		11
12	Social Services	107,552		1,518	109,070		109,070		109,070		12
13	Nurse Aide Training	29,440	3,566	13,680	46,686		46,686		46,686		13
14	Program Transportation			1,160	1,160		1,160	407	1,567		14
15	Other (specify):*							80	80		15
16	TOTAL Health Care and Programs	2,867,984	245,864	346,083	3,459,931		3,459,931	1,468	3,461,399		16
	C. General Administration										
17	Administrative	321,595		550,175	871,770		871,770	(261,431)	610,339		17
18	Directors Fees										18
19	Professional Services			96,805	96,805		96,805	(17,401)	79,404		19
20	Dues, Fees, Subscriptions & Promotions			271,903	271,903		271,903	(171,426)	100,477		20
21	Clerical & General Office Expenses	319,872	66,997	149,549	536,418		536,418	98,311	634,729		21
22	Employee Benefits & Payroll Taxes			715,016	715,016	26,828	741,844	(46,282)	695,562		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,304	10,304		10,304	1,233	11,537		24
25	Other Admin. Staff Transportation			1,286	1,286		1,286	377	1,663		25
26	Insurance-Prop.Liab.Malpractice			178,106	178,106		178,106	653	178,759		26
27	Other (specify):*							33,338	33,338		27
28	TOTAL General Administration	641,467	66,997	1,973,144	2,681,608	26,828	2,708,436	(362,628)	2,345,808		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,178,698	828,939	2,656,346	7,663,983		7,663,983	(374,349)	7,289,634		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			158,058	158,058		158,058	246,436	404,494			30
31	Amortization of Pre-Op. & Org.							97	97			31
32	Interest			369,018	369,018		369,018	658,394	1,027,412			32
33	Real Estate Taxes			381,448	381,448		381,448	176,890	558,338			33
34	Rent-Facility & Grounds			1,112,131	1,112,131		1,112,131	(1,085,008)	27,123			34
35	Rent-Equipment & Vehicles			16,634	16,634		16,634	9,588	26,222			35
36	Other (specify):*							30,421	30,421			36
37	TOTAL Ownership			2,037,289	2,037,289		2,037,289	36,818	2,074,107			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	15,424	130,616	707,683	853,723		853,723	45	853,768			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,327	136,327		136,327		136,327			42
43	Other (specify):*	327,601		56,416	384,017		384,017	(384,017)				43
44	TOTAL Special Cost Centers	343,025	130,616	900,426	1,374,067		1,374,067	(383,972)	990,095			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,521,723	959,555	5,594,061	11,075,339		11,075,339	(721,503)	10,353,836			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(291,048)	30		9
10	Interest and Other Investment Income	(171)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(342)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(27,500)	22		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,839)	21		18
19	Entertainment	(25,256)	21		19
20	Contributions	(20,060)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,569)	21		24
25	Fund Raising, Advertising and Promotional	(150,941)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(181)	20		28
29	Other-Attach Schedule	(482,020)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,060,927)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	339,424		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 339,424		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (721,503)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non-allowable Legal Expense	\$ (5,732)	19	1
2	Political Contributions - ICL/TC	(4,887)	20	2
3	Marketing Salary	(101,937)	43	3
4	Cable	(13,210)	5	4
5	Bank Charges	(984)	21	5
6	Food Rebates	(1,720)	2	6
7	Cupies	(315)	21	7
8	Cable	(750)	6	8
9	Out of Period Seminar Expense	(383)	24	9
10	Current Period Legal Fees	501	19	10
11	1999 Real Estate Taxes	(2,174)	33	11
12	Prior Period Clerical Salary/Payroll Taxes	(282,080)	43	12
13	Building Co. - Legal Fees	(21,699)	19	13
14	Building Co. - Accounting Fees	(6,625)	19	14
15	Prior Period Worker's Compensation	(18,782)	22	15
16	Collections	(4,342)	19	16
17	Construction in Progress Costs	(12,941)	19	17
18				18
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE AT MIDWAY# 0041749

Report Period Beginning:

01/01/01

Ending:

12/31/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			28									28	1
2	Food Purchase	(2,062)											(2,062)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,210)		880									(12,330)	5
6	Maintenance	(750)		1,890									1,140	6
7	Other (specify):*			35									35	7
8	TOTAL General Services	(16,022)		2,833									(13,189)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			981									981	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			407									407	14
15	Other (specify):*			80									80	15
16	TOTAL Health Care and Programs			1,468									1,468	16
	C. General Administration													
17	Administrative			1,844	(157,344)	(95,396)	(10,535)						(261,431)	17
18	Directors Fees													18
19	Professional Services	(54,798)	35,459	1,466			472						(17,401)	19
20	Fees, Subscriptions & Promotions	(176,069)		820			3,823						(171,426)	20
21	Clerical & General Office Expenses	(89,963)		182,567		4,515	1,192						98,311	21
22	Employee Benefits & Payroll Taxes	(46,282)											(46,282)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(383)		1,602			14						1,233	24
25	Other Admin. Staff Transportation			377									377	25
26	Insurance-Prop.Liab.Malpractice			653									653	26
27	Other (specify):*			26,909	3,326	742	2,361						33,338	27
28	TOTAL General Administration	(367,495)	35,459	216,238	(154,018)	(90,139)	(2,673)						(362,628)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(383,517)	35,459	220,539	(154,018)	(90,139)	(2,673)						(374,349)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(291,048)	531,794	5,690									246,436	30
31	Amortization of Pre-Op. & Org.		97										97	31
32	Interest	(171)	661,859	(3,294)									658,394	32
33	Real Estate Taxes	(2,174)	179,064										176,890	33
34	Rent-Facility & Grounds		(1,097,731)	12,723									(1,085,008)	34
35	Rent-Equipment & Vehicles			9,588									9,588	35
36	Other (specify):*		30,421										30,421	36
37	TOTAL Ownership	(293,393)	305,504	24,707									36,818	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			45									45	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(384,017)											(384,017)	43
44	TOTAL Special Cost Centers	(384,017)		45									(383,972)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,060,927)	340,963	245,291	(154,018)	(90,139)	(2,673)						(721,503)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **X** **YES** ☐ **NO**

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,097,731	Claridge at Cicero		\$	(1,097,731)	1
2	V	36	MIP Insurance		Claridge at Cicero		30,421	30,421	2
3	V	19	Fees		Claridge at Cicero		1,175	1,175	3
4	V	19	Legal Fees		Claridge at Cicero		27,659	27,659	4
5	V	19	Accounting		Claridge at Cicero		6,625	6,625	5
6	V	32	Interest Expense		Claridge at Cicero		661,859	661,859	6
7	V	33	Real Estate Taxes		Claridge at Cicero		179,064	179,064	7
8	V	30	Depreciation		Claridge at Cicero		531,794	531,794	8
9	V	31	Amortization		Claridge at Cicero		97	97	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,097,731			\$ 1,438,694	\$ * 340,963	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	NUCARE SERVICES CORP.	100.00%	\$ 28	\$ 28	15
16	V	5	UTILITIES		NUCARE SERVICES CORP.	100.00%	880	880	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	1,890	1,890	17
18	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.	100.00%	35	35	18
19	V	10	NURSING ADMIN. COMP.		NUCARE SERVICES CORP.	100.00%	981	981	19
20	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	407	407	20
21	V	15	HEALTHCARE BENEFITS		NUCARE SERVICES CORP.	100.00%	80	80	21
22	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.	100.00%	1,844	1,844	22
23	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	1,466	1,466	23
24	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	820	820	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	182,567	182,567	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,602	1,602	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	377	377	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	653	653	28
29	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	26,909	26,909	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	5,690	5,690	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	(3,294)	(3,294)	31
32	V	34	BUILDING RENT		NUCARE SERVICES CORP.	100.00%	12,723	12,723	32
33	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	9,588	9,588	33
34	V	39	ANCILLARY				45	45	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 245,291	\$ * 245,291	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	\$	NUCARE SERVICES CORP.	100.00%	\$ 97,314	\$	97,314
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	23,987		23,987
17	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,530		2,530
18	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			
19	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,099		2,099
20	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	1,030		1,030
21	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	197		197
22	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			
23	V								
24	V								
25	V	17	MANAGEMENT FEES	281,175	NUCARE SERVICES CORP.	100.00%			(281,175)
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 281,175			\$ 127,157	\$ *	(154,018)

* Total must agree with the amount recorded on line 34 of Schedule VI.

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 13,465	\$ 13,465	15
16	V	19	PROFESSIONAL FEES				472	472	16
17	V	20	FEES, SUBSCRIPTIONS				3,823	3,823	17
18	V	21	CLERICAL AND GENERAL				1,192	1,192	18
19	V	24	SEMINARS				14	14	19
20	V	27	GEN ADMIN.- EMP. BEN.				2,361	2,361	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	24,000				(24,000)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 24,000			\$ 21,327	\$ * (2,673)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number	RENAISSANCE AT MIDWAY
--------------------------------------	------------------------------

0041749

Report Period Beginning: 01/01/01

Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3	4	5	6	7	8	
Schedule V			Cost Per General Ledger		Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	20.05%	See Attached	4.93	7.58%	Alloc. Salary	\$ 97,314	17-7	1
2	Robert Hartman	Owner	Administrative	20.05%	See Attached	4.93	7.58%	Mgmnt Fees	120,000	17-3	2
3	Barry Carr		Administrative		See Attached	5.40	12.00%	Alloc. Salary	23,987	17-7	3
4	Barry Carr		Administrative		See Attached	5.40	12.00%	Salary	37,385	17-1	4
5	Mark Berger		Administrator		See Attached	40	80.00%	Alloc. Fees	8,000	17-7	5
6	Mark Berger		Administrator		See Attached	40	80.00%	Salary	100,116	17-1	6
7	Mark Berger		Administrator		See Attached	40	80.00%	Mgmnt Fees	5,000	17-3	7
8	Jack Rajchenbach	Owner	Administrative	25.00%	See Attached	6	9.20%	Alloc. Salary	16,604	17-7	8
9	David Hartman		Administrative		See Attached	.70	1.55%	Alloc. Salary	2,530	17-7	9
10	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2	3.07%				10
11											11
12											12
13								TOTAL	\$ 410,936		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 12/31/01

Facility Name & ID Number RENAISSANCE AT MIDWAY# 0041749

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

NUCARE SERVICES CORP.

Street Address

6677 N LINCOLN AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 933-2600

Fax Number

(847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. CENSUS DAYS	672,540	8	\$ 205	\$	90,885	\$ 28	1
2	5	UTILITIES	AVAIL. CENSUS DAYS	672,540	8	6,508		90,885	880	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	672,540	8	13,988	1,054	90,885	1,890	3
4	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	672,540	8	258		90,885	35	4
5	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	672,540	8	7,261	2,431	90,885	981	5
6	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	672,540	8	3,009		90,885	407	6
7	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	672,540	8	595		90,885	80	7
8	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	672,540	8	13,648	8,000	90,885	1,844	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	672,540	8	10,851		90,885	1,466	9
10	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	672,540	8	6,065		90,885	820	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	672,540	8	1,350,975	1,102,702	90,885	182,567	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	672,540	8	11,855		90,885	1,602	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	672,540	8	2,788		90,885	377	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	672,540	8	4,831		90,885	653	14
15	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	672,540	8	199,124		90,885	26,909	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	672,540	8	42,107		90,885	5,690	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	672,540	8	(24,377)		90,885	(3,294)	17
18	34	BUILDING RENT	AVAIL. CENSUS DAYS	672,540	8	94,150		90,885	12,723	18
19	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	672,540	8	70,953		90,885	9,588	19
20	39	ANCILLARY	AVAIL. CENSUS DAYS	672,540	8	335	269	90,885	45	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,815,129	\$ 1,114,456		\$ 245,291	25

Facility Name & ID Number RENAISSANCE AT MIDWAY# 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization NUCARE SERVICES CORP.
 Street Address 6677 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	720,115	720,000	4.93	97,314	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40.00	8	177,679	175,000	5.40	23,987	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	18,073	17,000	0.70	2,530	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	20,728	19,166			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	15,535		4.93	2,099	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40.00	8	7,632		5.40	1,030	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	1,411		0.70	197	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	1,576				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 962,749	\$ 931,166		\$ 127,157	25

Facility Name & ID Number RENAISSANCE AT MIDWAY# 0041749

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

JLR MANAGEMENT CORP.

Street Address

6633 NORTH LINCOLN

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 679-9141

Fax Number

(847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	61	9	\$ 168,808	\$ 168,808	6	\$ 16,604	1
2	21	OFFICE	AVG. HOURS WORKED	61	9	5,235		6	515	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	61	9	7,543		6	742	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HOURS WORKED	50	2	10,000		40	8,000	10
11	21	SECRETARIAL	AVG. HOURS WORKED	50	2	5,000		40	4,000	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 232,882	\$ 168,808		\$ 29,861	25

Facility Name & ID Number RENAISSANCE AT MIDWAY# 0041749

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

CAREPATH HEALTH NETWORK

Street Address

6633 N LINCOLN AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(888) 707-6700

Fax Number

(847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	\$ 353,316	\$ 353,316	24,000	\$ 13,465	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396		24,000	472	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317		24,000	3,823	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275		24,000	1,192	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366		24,000	14	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960		24,000	2,361	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 559,630	\$ 353,316		\$ 21,327	25

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Diamond Insurance
Street Address 40 Skokie Blvd., Suite 105
City / State / Zip Code Northbrook, IL 60062
Phone Number (847) 559-1002
Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Worker's Comp. Insurance	Direct Allocation			\$	\$		\$ 54,535	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 54,535	25

Ending: 12/31/01

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RENAISSANCE AT MIDWAY # 0041749 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Shareholders	X						1,500,000				90,669	6	
7	American Nat'l Bank		X	Line of Credit								208,998	7	
8	CIB Bank		X	Line of Credit								35,004	8	
9	TOTAL Facility Related						\$	1,500,000				\$	334,671	9
	B. Non-Facility Related*													
10	See Supplemental Schedule							9,468,370				658,852	10	
11	Cole Taylor Bank		X	Line of Credit								33,889	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	9,468,370				\$	692,741	14
15	TOTALS (line 9+line14)						\$	10,968,370				\$	1,027,412	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number

RENAISSANCE AT MIDWAY

0041749

Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
1	Other		X				\$					\$	458	1	
2	NuCare Allocation	X											(3,294)	2	
3	Interest Income		X										(171)	3	
4	Claridge at Cicero, LP	X		Mortgage					9,468,370				661,859	4	
5														5	
6														6	
7														7	
8														8	
9														9	
10														10	
11														11	
12														12	
13														13	
14														14	
15														15	
16														16	
17														17	
18														18	
19														19	
20														20	
21							\$		\$	9,468,370			\$	658,852	21

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

RENAISSANCE AT MIDWAY

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0041749

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. See Attached Schedule		\$	\$ 356,609.95
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$ 356,609.95

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

RENAISSANCE AT MIDWAY

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0041749

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE (847) 236-1111

FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	19-03-304-009-0000	Long-Term Care Property	\$ 1,520.22	\$ 1,520.22
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 1,520.22	\$ 1,520.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **98,303**

B. General Construction Type: Exterior **Brick** Frame **Steel** Number of Stories **4**

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: **97** 4. Dates Incurred:

Nature of Costs: **Loan Fees**

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	48,972	1994	\$ 850,000	1
2					2
3	TOTALS	48,972		\$ 850,000	3

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	249		2000	2000	\$ 9,107,497	\$ 238,755	35	\$ 260,214	\$ 21,459	\$ 412,006	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
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25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)	3,219	167		157	(10)	400	68
69	Financial Statement Depreciation		158,058			(158,058)		69
70	TOTAL (lines 4 thru 69)	\$ 9,110,716	\$ 396,980		\$ 260,371	\$ (136,609)	\$ 412,406	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT MIDWAY

0041749

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,110,716	\$ 396,980		\$ 260,371	\$ (136,609)	\$ 412,406	1
2	CORNER GUARDS	2000	1,438		20	72	72	114	2
3	CARPET & DRAPERIES	2000	3,622		20	181	181	287	3
4	WALLPAPER	2000	1,277		20	64	64	101	4
5	DRAPERIES & SHWR CBL	2000	1,758		20	88	88	139	5
6	CABINETS	2000	6,200		20	310	310	491	6
7	CABINETS	2000	1,980		20	99	99	157	7
8	LOCKS	2000	611		20	31	31	49	8
9	AMERICAN HEALTHCARE	2000	488		20	24	24	38	9
10	GRAVEL FOR PRKG LOT	2000	3,500		20	175	175	277	10
11	WINDOWS	2000	3,933		20	197	197	312	11
12	FENCE	2000	2,215		20	111	111	176	12
13	INSTL WNDW GRD SYSTM	2000	13,170		20	659	659	1,043	13
14	SIGNS	2000	415		20	21	21	33	14
15	WIRING FOR PHONES,CO	2000	28,197		20	1,410	1,410	2,233	15
16	WALLPAPER	2000	4,039		20	202	202	320	16
17	CARPET	2000	1,123		20	56	56	89	17
18	WINDOW TREATMENTS	2000	1,244		20	62	62	98	18
19	FRNSH & INSTL FLG PL	2000	1,471		20	74	74	117	19
20	BALANCE OWED ON CNPS	2000	7,804		20	390	390	585	20
21	INSTALL LANDSCAPING	2000	9,637		20	482	482	723	21
22	WINDOW TREATMENT	2000	3,992		20	200	200	300	22
23	WINDOW TREATMENT	2000	483		20	24	24	36	23
24	CORNICE BRDS & VLNCS	2000	3,794		20	190	190	285	24
25	PREP WALLS & HNG WLP	2000	5,980		20	299	299	449	25
26	PREP WALLS & HNG WLP	2000	3,990		20	200	200	283	26
27	CHR RLS, END CAP,WLG	2000	6,605		20	330	330	468	27
28	PHONE & CMPTR CBLG	2000	4,959		20	248	248	351	28
29	WALLPAPER	2000	208		20	10	10	14	29
30	CORNICE BRDS, DRAPER	2000	1,194		20	60	60	85	30
31	WINDOW TREATMENTS	2000	6,442		20	322	322	456	31
32	CUBICLE CRTNS, SHDS	2000	3,798		20	190	190	269	32
33	PRVDE A/C TO STF DNR	2000	1,716		20	86	86	122	33
34	TOTAL (lines 1 thru 33)		\$ 9,247,999	\$ 396,980		\$ 267,238	\$ (129,742)	\$ 422,906	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT MIDWAY

0041749

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,247,999	\$ 396,980		\$ 267,238	\$ (129,742)	\$ 422,906	1
2	<u>CCTV & CMPTR CABLEIN</u>	2000	5,056		20	253	253	358	2
3	<u>INHOUSE PAGING SYSTM</u>	2000	5,554		20	278	278	371	3
4	<u>FLUID PUMP SERVICE</u>	2000	1,246		20	62	62	83	4
5	<u>SCREENS</u>	2000	630		20	32	32	40	5
6	<u>REPLC FLR IN SRVC EL</u>	2000	1,750		20	88	88	110	6
7	<u>SQUARE DEAL GLASS</u>	2000	626		20	31	31	39	7
8	<u>WANDER GUARD SYSTEM</u>	2000	1,088		20	54	54	63	8
9	<u>INSTALL PHONE SYSTEM</u>	2000	8,600		20	430	430	502	9
10	<u>PHONE, CCTV & CMPTR</u>	2000	16,579		20	829	829	967	10
11	<u>REPAIRS TO BOILER</u>	2000	927		20	46	46	50	11
12	<u>INSTALL PHONE SYSTEM</u>	2000	4,861		20	243	243	263	12
13	<u>CABLEING FOR CMPTR S</u>	2000	604		20	30	30	33	13
14	<u>REPAIR FIRE ALARM PN</u>	2000	866		20	43	43	61	14
15	<u>BED, MOBILE MONITOR</u>	2000	627		20	63	63	100	15
16	<u>ILLUMINATED WALL DIS</u>	2000	27,983		20	1,399	1,399	1,399	16
17	<u>REPR FRNT ENTRNC DR</u>	2001	425		20	21	21	21	17
18	<u>INSTALL ROOF ON OXYG</u>	2001	565		20	28	28	28	18
19	<u>MISC ELECTRICAL WORK</u>	2001	9,697		20	485	485	485	19
20	<u>BUILD MNTNC OFFICE W</u>	2001	2,890		20	133	133	133	20
21	<u>TILE</u>	2001	607		20	25	25	25	21
22	<u>ELEVATOR REPAIRS</u>	2001	957		20	40	40	40	22
23	<u>REPLC DR RELS ON DR</u>	2001	498		20	19	19	19	23
24	<u>CANOPY</u>	2001	10,694		20	357	357	357	24
25	<u>PARKING LOT DESIGN</u>	2001	1,800		20	60	60	60	25
26	<u>WALLPAPER</u>	2001	1,765		20	59	59	59	26
27	<u>WINDOW</u>	2001	251		20	9	9	9	27
28	<u>INSTALL ELECT FOR SG</u>	2001	2,846		20	95	95	95	28
29	<u>LANDSCAPING REPRS</u>	2001	2,188		20	64	64	64	29
30	<u>REPAIR WATER LEAK</u>	2001	689		20	17	17	17	30
31	<u>REPAIR FIRE ALARM</u>	2001	671		20	23	23	23	31
32	<u>REPR FIRE ALARM</u>	2001	(209)		20	(8)	(8)	(8)	32
33	<u>REPR FIRE ALRM</u>	2001	711		20	18	18	18	33
34	TOTAL (lines 1 thru 33)		\$ 9,362,041	\$ 396,980		\$ 272,564	\$ (124,416)	\$ 428,790	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,362,041	\$ 396,980		\$ 272,564	\$ (124,416)	\$ 428,790	1
2	ARCHITECHTURAL FEES	2001	1,872		20	39	39	39	2
3	IN-HSE PG SYSTEM	2001	1,305		20	27	27	27	3
4	2 WINDOWS	2001	502		20	13	13	13	4
5	ARCHITECTURAL SVS/PM	2001	2,100		20	18	18	18	5
6	REPLC STMR, INSTL AR	2001	685		20	3	3	3	6
7	SPRINKLER REPAIRS	2001	925		20	31	31	31	7
8	INSTLN/REPR OF PHN/C	2001	2,603		20	11	11	11	8
9	SMOKE DETECTOR	2001	537		20	18	18	18	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,372,570	\$ 396,980		\$ 272,724	\$ (124,256)	\$ 428,950	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Allocation - Nucare Management		1997		622	16	20	31	15	131
10	Allocation - Nucare Management		1998		545	14	20	27	13	94
11	Allocation - Nucare Management		1999		764	106	20	38	(68)	93
12	Allocation - Nucare Management		2000		929	24	20	46	(22)	67
13	Allocation - Nucare Management		2001		359	7	20	15	8	15
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,219	\$ 167		\$ 157	\$ (54)	\$ 400	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,258,677	\$ 297,547	\$ 125,358	\$ (172,189)	10	\$ 207,707	71
72	Current Year Purchases	86,990	1,015	6,412	5,397	10	6,412	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,345,667	\$ 298,562	\$ 131,770	\$ (166,792)		\$ 214,119	75

D. Vehicle Depreciation (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	11,568,237 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	695,542 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	404,494 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(291,048) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	643,069 85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	PROCESSING , INSPECTION, EXAM	\$ 203,948	\$	\$ 86
87				87
88				88
89				89
90				90
91	TOTALS	\$ 203,948	\$	\$ 91

G. Construction-in-Progress		
	Description	Cost
92	See Attached Schedule	\$ 12,941 92
93		93
94		94
95		\$ 12,941 95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Parking				14,400			5
6	Allocation from Nucare				12,723			6
7	TOTAL				\$ 27,123			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy: YES NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YESNO

16. Rental Amount for movable equipment: \$ 17,377 Description: \$7789 Copy Machine; Allocation from NuCare \$9588

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	Honda-1998 Acura	\$ 700	\$ 1,935	17
18	Business	Honda-2001 Acura	691	6,910	18
19					19
20					20
21	TOTAL		\$ 1,391	\$ 8,845	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☒

HOURS PER AIDE

120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☒

IN OTHER FACILITY

☐

HOURS PER AIDE

80

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 985	\$ 12,695	\$	\$ 13,680
2	Books and Supplies	324	3,242		3,566
3	Classroom Wages (a)				
4	Clinical Wages (b)	2,676	26,764		29,440
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 3,985	\$ 42,701	\$	\$ 46,686
10	SUM OF line 9, col. 1 and 2 (e)	\$ 46,686			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	30
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	33

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678												
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	164,867	\$		\$	164,867	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				24,725				24,725	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				187,909				187,909	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 03	# of prescripts				330,182				330,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):				15,424			130,616			146,040	13
14	TOTAL				\$ 15,424		\$ 707,683	\$ 130,616		\$	853,723	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 11,842	\$ 256,792	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,472,457	4,472,457	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,701	119,921	6
7	Other Prepaid Expenses	10,882	10,882	7
8	Accounts Receivable (owners or related parties)	742,396	742,396	8
9	Other(specify): See supplemental schedule	60,097	168,905	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,395,375	\$ 5,771,353	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		904,865	13
14	Buildings, at Historical Cost		8,058,906	14
15	Leasehold Improvements, at Historical Cost	248,781	248,781	15
16	Equipment, at Historical Cost	469,984	1,299,339	16
17	Accumulated Depreciation (book methods)	(208,337)	(966,311)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,258,036	22
23	Other(specify): See supplemental schedule	1,743	1,743	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 512,171	\$ 10,805,359	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,907,546	\$ 16,576,712	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,437,085	\$ 2,437,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,480	1,480	28
29	Short-Term Notes Payable	1,500,000	1,500,000	29
30	Accrued Salaries Payable	196,434	196,434	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,083	24,083	31
32	Accrued Real Estate Taxes(Sch.IX-B)	175,423	374,441	32
33	Accrued Interest Payable		56,416	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	633	633	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	5,087,558	6,262,371	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,422,696	\$ 10,852,943	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,468,370	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,468,370	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,422,696	\$ 20,321,313	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,515,150)	\$ (3,744,601)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,907,546	\$ 16,576,712	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,856,695)	1
2	Restatements (describe):		2
3	See Attached	(158,808)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,015,503)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(499,647)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (499,647)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,515,150)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **RENAISSANCE AT MIDWAY**# **0041749**Report Period Beginning: **01/01/01**

Ending:

12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,491,762	1
2	Discounts and Allowances for all Levels	(381,062)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,110,700	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	792,106	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 792,106	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	506,768	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	60,285	19
20	Radiology and X-Ray		20
21	Other Medical Services	102,705	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 669,758	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	171	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 171	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	2,957	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,957	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,575,692	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,522,444	31
32	Health Care	3,459,931	32
33	General Administration	2,681,608	33
	B. Capital Expense		
34	Ownership	2,037,289	34
	C. Ancillary Expense		
35	Special Cost Centers	1,237,740	35
36	Provider Participation Fee	136,327	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,075,339	40
41	Income before Income Taxes (line 30 minus line 40)**	(499,647)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (499,647)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number RENAISSANCE AT MIDWAY# 0041749

Report Period Beginning:

01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,008	2,078	\$ 73,309	\$ 35.28	1
2	Assistant Director of Nursing	3,809	4,520	145,190	32.12	2
3	Registered Nurses	27,934	30,202	650,243	21.53	3
4	Licensed Practical Nurses	32,487	34,080	612,393	17.97	4
5	Nurse Aides & Orderlies	110,944	115,495	914,857	7.92	5
6	Nurse Aide Trainees	3,462	3,626	29,440	8.12	6
7	Licensed Therapist	458	458	15,424	33.68	7
8	Rehab/Therapy Aides	5,251	5,766	48,266	8.37	8
9	Activity Director	3,265	3,451	60,086	17.41	9
10	Activity Assistants	12,831	13,766	104,371	7.58	10
11	Social Service Workers	8,685	9,437	107,552	11.40	11
12	Dietician	2,495	2,764	54,050	19.55	12
13	Food Service Supervisor					13
14	Head Cook	5,183	5,473	54,215	9.91	14
15	Cook Helpers/Assistants	21,901	22,476	170,825	7.60	15
16	Dishwashers					16
17	Maintenance Workers	5,631	5,936	96,432	16.25	17
18	Housekeepers	25,852	27,119	223,349	8.24	18
19	Laundry	9,652	10,084	70,376	6.98	19
20	Administrator	1,872	2,045	100,116	48.96	20
21	Assistant Administrator	1,975	2,086	55,560	26.63	21
22	Other Administrative	2,399	2,399	165,919	69.16	22
23	Office Manager					23
24	Clerical	30,246	33,511	319,872	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,058	5,484	122,277	22.30	31
32	Other Health Care(specify)					32
33	Other(specify)	14,270	14,862	327,601	22.04	33
34	TOTAL (lines 1 - 33)	337,668	357,118	\$ 4,521,723 *	\$ 12.66	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	182	\$ 8,168	01-03	35
36	Medical Director	Monthly	20,004	09-03	36
37	Medical Records Consultant	44	1,980	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,488	10-03	39
40	Physical Therapy Consultant	54	2,828	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	287	10a-03	43
44	Activity Consultant	48	2,437	11-03	44
45	Social Service Consultant	30	1,518	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	364	\$ 41,710		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,448	\$ 133,422	10-03	50
51	Licensed Practical Nurses	3,001	91,114	10-03	51
52	Nurse Aides	4,103	73,165	10-03	52
53	TOTAL (lines 50 - 52)	10,552	\$ 297,701		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Mark Berger	Administrator	0	\$ 100,116	Workers' Compensation Insurance	\$	54,535	IDPH License Fee	\$			
Brian Celerio	Asst. Admin.	0	55,560	Unemployment Compensation Insurance		80,446	Advertising: Employee Recruitment		72,178		
Kathy Brander (NuCare)	Dir of Reg. Mgmt.	0	3,454	FICA Taxes		306,904	Health Care Worker Background Check		7,957		
Ray Dolan (NuCare)	VP Risk Mgmt.	0	40,970	Employee Health Insurance		71,363	(Indicate # of checks performed 834)				
Patt Finn (NuCare)	President Renaissance		84,109	Employee Meals		26,828	Yellow Page Advertising		181		
Barry Carr	President		37,385	Illinois Municipal Retirement Fund (IMRF)*			Dues, Fees, Subscriptions		7,099		
TOTAL (agree to Schedule V, line 17, col. 1)				Chicago Head Tax		7,808	License & Inspections		8,600		
(List each licensed administrator separately.)			\$ 321,594	Union Health Insurance		71,947	Allocation from Carepath		3,823		
				Union Pension Benefits		17,466	Allocation from Nucare		820		
B. Administrative - Other				Other Employee Benefits		55,254					
Description			Amount	401K		3,011					
Management Fees - See Attached Schedule			\$ 550,175				Less: Public Relations Expense				
							Non-allowable advertising				
							Yellow page advertising		(181)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 550,175	TOTAL (agree to Schedule V, line 22, col.8)			\$ 695,562	TOTAL (agree to Sch. V, line 20, col. 8)			
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
C. Professional Services				Description			Description				
Vendor/Payee	Type	Amount		Line #			Amount				
See Attached	Legal	\$ 65,095					\$				
Frost Ruttenberg & Rothblatt	Accounting	8,157									
Power Software	Computer	8,133									
Health Data Systems	Computer	8,469									
Horizon Healthcare Technology	Computer	2,289									
AOL Online	Computer	430									
Personnel Planners	Unemployment Consult.	1,863									
Terrence O'Brien & Co.	Real Estate Appraiser	1,495									
Suburban Surveying Service	Surveyor	875									

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number		RENAISSANCE AT MIDWAY		STATE OF ILLINOIS	#	0041749	Report Period Beginning:	01/01/01	Ending:	12/31/01	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>							
	If YES, give association name and amount.			<u>Illinois Council on LTC \$10,934</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>Yes</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?										
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>27,646</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.										
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES <u>NO</u> <u>X</u>							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.			\$ <u>136,327</u>							
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			<u>No</u>							
	If YES, attach an explanation of the allocation.										
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			<u>No</u>							
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$ <u>26,828</u>							
	Has any meal income been offset against related costs?			<u>No</u>							
	Indicate the amount.			\$							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% In 1</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>No</u>							
	Firm Name:										
	The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?										
	If no, please explain.										
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			<u>Yes</u>							
	Attach invoices and a summary of services for all architect and appraisal fees										